Psychiatric Problems in Children

Part II

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IN the article printed in the May issue of this journal, three large groups or kinds of psychiatric disorders of children were reviewed. I suppose that in certain important respects they are of least interest to a group of general practitioners. The syndromes of childhood neurosis, psychosis and aggressive behavior disorder are all of them least likely to come to your attention—or at least, less often than some others. These syndromes are really the end-products or, more precisely, very extreme forms of psychiatric disorder in childhood. They require relatively little specialized experience or training to recognize and their severity and chronicity are such as to require the time as well as the competence which the busy practitioner cannot perhaps be expected to possess and to give. Also it is probably less important that the correct, shorthand diagnostic title be applied to the disorder by the physician who is consulted about one of these severe disorders than that he direct the family to appropriate facilities prepared to make some effort for the care and treatment of the patient.

This referral for treatment is of itself a serious problem because of the great shortage of psychiatric clinics for children everywhere in this country and of insufficient trained personnel to staff such clinics as exist. The amount of time as well as trained skill (which itself takes years to acquire) which is necessary to be even of some help in these serious disorders is such that most existing clinics even with fairly large staffs are usually overburdened and struggle with long waiting lists for admission.

Nevertheless, there may have been some advantage in reviewing these gross clinical forms of disorder. The advantage consists in that they may be orientation points from which to understand the overwhelming majority of minor, less severe disturbances of children, most of which do not come very near to fitting into any of the three categories that were reviewed. I mean that a very great number of children brought not only to general practitioners but to child psychiatrists as well have symptoms—or at least their parents have complaints about them—which cannot be easily classified either as neurotic or psychopathic. Such children show mixtures of both types of difficulty—that is, symptoms of neurosis and of behavior disorder concurrently. They manifest, in other words, peculiar combinations of neurotic conflict *and* difficulty in self-restraint of their hostile aggressive or of their innate egocentric impulses. One sees, for example, quite frequently children who, in certain situations or at certain times, find it impossible to restrain their cruelty, or to be frank, honest, and to respect others' property and at other time show severe phobias, night terrors, or other somatic neurotic symptoms.

COMPLAINTS FREQUENTLY MADE BY PARENTS

Parents also complain that a child may be at once intimidated and fearful with his peers and excessively autocratic and abusive with younger children or siblings, while at the same time fidgety, restless generally, a poor sleeper and subject to frequent gastrointestinal upsets. Frequent, too, are the complaints about the difficulty in acquiring personal and social habits or discarding more infantile traits at later chronological ages. Persistent thumb-sucking, for example, with the current warnings from orthodontists that it may lead to severe malformation of the dental arches, is a frequent subject of much parental anxiety. Enuresis, diurnal as well as nocturnal, and recurrent fecal soiling, poor appetite with some malnutrition and susceptibility to minor infections, or frequent and severe temper tantrums, destructive and violent hostility to a younger sibling expressing unresolved, extreme rivalry, and a host of other such individual complaints with little or no evidence of a more total or severe neurotic disorder, may be the immediate reason for the consultation. Masturbation, excessive sexual curiosity and preoccupation often frighten parents, while repeated episodes of stealing sometimes raise visions of future criminality. Literally, the list of such individual combinations of symptoms and behavior difficulties is almost inexhaustible and I am certain it can be supplemented almost endlessly by everyone of you out of your own experience in practice. All this does not even touch upon a similar variety of difficulties and anxieties parents have with infants and young children under two or three years of age with respect to feeding, elimination, general health and primary socialization and domestication in habit training of cleanliness, self-care, and so forth.

All these congeries of symptoms and problems, all these less severe and in-between conditions, make it necessary to formulate a wider conceptual frame-

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work and viewpoint than that of the traditional nosological entities we have discussed. We need, in other words, a way of looking at the otherwise bewildering variety of physiological and psychological disturbances of children which will be more useful to the medical man than the notions of individual neurosis, psychosis or behavior disorder. It is at this point that I feel I can tell the experienced general practitioner little that he does not already know and understand.

The physician established for some years in a community begins to know not only the physiological condition of the individual patient, child or adult, who may over a period of time consult him repeatedly. He begins to know his patient as a person, that is, as a unique member of a particular family and of other groups with a particular vocation and avocational interests and adjustments, with particular hobbies, preferences, aversions, with a certain intelligence and social and economic and educational background and status; in short, the physician comes to know the patient's advantages and disadvantages. The physician acquires in his repeated visits to the home or as a result of indirect information from other patients and other members of the community a great deal of knowledge and information about the family which is highly relevant from the psychiatric point of view—or, better, from the point of view of total, or integrated medicine. (Some people prefer to use the currently popular term of "psychosomatic medicine.") The doctor learns in the form of privileged communication, or from his direct observations while in the home, what the actual relations of various members of the family to one another and to others in the community are. He learns how the mother feels and treats the father and vice versa, how each of them feels about and treats each of their children, and how each is still tied to, rebellious against, or comfortably independent of, his own parents or the in-laws. Who better than the doctor—except, perhaps, the minister, priest or lawyer—knows the crises of the family's life and its recurrent problems in living? If the physician has some of the equanimity which Osler extolled, if he acquires the wisdom, patience, firmness, which may come with experience, maturity and age, he will be and often is admitted further than into the physical sanctum of the private sick-room of the home. He will be admitted to some of the inner recesses of the family's guarded secrets, confidences and troubles; in short, he will be admitted to their feelings. If over the years he proves himself a worthy confidant, a sturdily optimistic, fair-minded helper in those crises for which his assistance is sought, if he respects himself and all the potentialities and values of each of the persons of the whole family, he becomes gradually invested, by their feelings for him, with a therapeutic power for their welfare which with the chemicals he prescribes or the operations he performs on their bodies may perform even greater miracles of healing than perhaps even he thought were possible.

What I am trying to say in perhaps a roundabout way is that from the point of view of the child's welfare—somatic and psychological—this position and role of the family physician carries with it at least the possibility of all the knowledge necessary to understand the queerest quirk of the child's behavior and emotional state. This position, this relation of the doctor to the family—symbolized by the emotionally charged and mutually meaningful phrases of "our doctor" and "my patients" or "my family"—also has, as all of you very well know, psychotherapeutic potentialities already implicit in it which it may take a psychiatrist or a psychiatric clinic staff weeks, months, or longer to achieve.

In other words, the child is a human organism, at first utterly, and later relatively, dependent upon its parents or other adults, who is always tremendously affected in whatever genetic potentialities he has by not only the impersonal food, protection against extremes of temperature, and against infection or other injury, but also by the totality of the personal, the feeling, environment. As a matter of fact, it is becoming clearer and clearer to most of us that even superior intelligence and the most robust physical inheritance and measures to provide minimal standards of somatic health and care do not necessarily by themselves insure the fullest development and solid integration of the person. The human animal becomes the kind of human being which his immediate personal, familial environment and later social situation permit him to develop into, with his particular, genetically acquired potentialities. If he is wanted, if his parents enjoy having him, and if he finds a stable justice as between himself and his siblings, the young human animal has then a good chance of coming *to feel* as a worthwhile, self-respecting person and member of his family and later of any larger communal group. If his earliest and *necessarily egocentric,* sensual needs of self-exploration, of muscular activity and developing skills are gratified and are not stunted by whatever dark anxieties adults often have, he is not likely at one and the same time to be driven faster and farther than his given maturational stage can take easily, and not likely to become divided in himself, guilty and anxious about some of his bodily impulses and sensations and hence secretly and insatiably longing to return to kinds and quantities of sensation and behavior really denied and prohibited to him earlier. If, on the other hand, he is not smothered by an anxious oversolicitude which has more to do with a mother's or father's secret longing to relive some indulgences denied *them* as children rather than with the child's actual needs for care, for easy warmth of affection, for opportunities for independent trial-and-error learning, and for mastery of his emerging muscular power and dexterity, then the child can also gradually and as a matter of course accept *as his own attitudes,* that is, identify with, such general rules of respect for the feelings and welfare of others as are indispensable to organized, interdependent, social living. If at all

stages of his growth real and basic respect is paid to his rights within the family community; if he is frankly, firmly and honestly dealt with; if opportunities for his play, pleasure and learning are provided as generously as is possible; if his faltering efforts at learning are not derided; if his failures are met with steady sympathy and encouragement and with no trace of the pity which so often hides some gleeful contempt, then he will reflect this experience later in a sturdy, courageous, honest sense of self-respect which will be infused with realistic optimism and a generosity first towards himself and then towards others which will not permit exploitation by others, nor demand ingratiating submissiveness from them. Under such circumstances hateful envy may be minimal, and capacity to benign helpfulness, to collaboration with others of his communal groups, and even more important, a deep ability to love a mate fully may be maximal with neither unnecessary inhibitions in sexual satisfaction nor guilty and obsessional preoccupation with partial eroticisms. What is more, such a child, as a later adult, with neither secret nor repressed longing for childhood satisfactions nor fear of their healthy gratifications, can—*as a parent*—permit *his* child also to live through each developmental period with minimal qualms, maximal security, and thus contribute to his solid and unhurried growth into adolescence and adulthood.

Merely to recount such "ifs" about a child's experience with adults is, I think, sufficient to make my point. It suffices, I hope, to recall to your minds the numerous family situations which you have known and know currently in which many of these "if" conditions were wholly or partially absent. It is probably unnecessary for me to detail some of the typical difficulties which make it almost impossible for parents to provide in their own feelings towards themselves and each other even an approach to these ideals of emotional atmosphere for their child or their children. We all of us know how often parents of the present generation grew up in a home, in a community, in a world quite different from the one they live in now. By different, I mean, of course, one which did not prepare them as well as it might for the present world. *Their* parents may have been born in another part of the world, with another language, with customs different from those in the United States of America, with attitudes towards children and life which did not easily mesh with those of people around them in this country. Their life may have been difficult economically and socially. If these parents of present parents *were* born in this country, they may also have had different attitudes and customs than this country generally had or has now.

In any case, it is not uncommon that the life of present parents during their childhood did not prepare them to live with sufficient equanimity through major, widespread, violently fluctuating economic cycles, perhaps through two world wars, and to the rapidly changing relations of nations of the world to one another with atomic energy as a new sword of Damocles hanging over all. Although intelligent, they may either not have had the opportunity nor learned the persistence to get adequate training of their potential skills to assure them a satisfying vocation and status later. A good many mothers of this generation have had less experience of helping *their* mothers with housework, and they have learned that at least to some extent a woman is almost as good as a man in many occupations and professions. This newer freedom—exemplified by less general horror about their smoking, drinking, going to various schools of higher learning and even participating in many sports and athletics—however, is still only partial and, I suppose, many men still dislike to feel their wives are as smart as they, or could earn almost as much money as they, and sometimes could get along without them. Notice here that these more and more rapidly changing mores of intersexual relations affect both the men *and* the women. Neither is wholly sure what he or she may be or ought to be in relation to the other. Oscillations in both men and women between the old attitudes (man dominantly superior — woman submissively and clingingly inferior) and the new not yet clearly established attitudes of some equality of value as persons of both sexes are frequent. Secret envies, buried but covertly active, hatreds in both for themselves and each other are often laughingly mentioned as the "eternal war between the sexes," but they wreak havoc upon marital happiness, upon adequate sexual satisfaction and, not least, for our problem here, upon successful parenthood.

These changing customs, attitudes and ethics are general conditions, you may say, and not necessarily true of a particular family, and, in a sense, you will be correct. In a specific family history it is more important to learn what happened and is happening to lessen the satisfactions and the security of the parents as adult citizens in a particular community. (In this connection, how frequent is it that families have since their grandparents' day remained in the same community, with their own home, their own familial status?) Has the father the job he enjoys with fairly certain prospects of continued employment, of improvement in salary and status, security for health and old age? Does he worry about how much he owes to his old widowed mother, or does he fret about how much longer he'll be able to stand his mother-in-law around, either in his own home or nearby? Is he tempted to thoughts or deeds of infidelity and does he feel guilty about it because his wife has aged, is too tired, too harried, or too insistently demanding that he continue to baby *her* as well as the children? Does his wife become more panicky at all these more or less subtle signs of loss of his affection, and, in reaction, either naggingly demand more than he can give or become entangled with one or more of her children emotionally who in

turn reacts with a mixture of rebelliousness and neurotic anxiety? Did the parents of either of the parents die at a time critically difficult for either the husband or the wife? Did either the father or the mother immediately upon birth prefer the son or the daughter with corresponding resentful reaction of the rest of the family at their exclusion? Did the second child come too soon after the first one, or at a time when the tension between the parents was highest in their marital history? Was the child only more or less the trick of either parent upon the other to bind the straying one? Or, was the child the result of a sentimentally, but self-deceptively, agreed contract between them to save their marriage after some years of sterility when it was near its ebb; and incidentally, was it urged upon them by friends or even by their doctor? Or, finally, was the child in common parlance an "accident" at a time when neither parent felt ready for it? Again, was the child of the sex opposite to that hoped for and desired by both?

These and many, many other similar questions about the actual, even if hidden, facts and combination of events in the family's life need to be considered as possibilities in the etiology of whatever emotional, behavioral or psychosomatic disorder the child may manifest at a given age. When the child is older and has perhaps lived through some of these unfortunate familial circumstances and events, it may seem as if extrafamilial difficulties in living were more important etiological factors. There may not be enough children of the right age, of the right sex, from the "right kind" of homes to play with. There may be too many children in the class; the teacher may seem too unjust to the particular child. He may not have won some special recognition in school, or he may have failed in some other way. All these extrafamilial conditions and events may be *there* and not only in the defensive imagination of the parents. But close study often, if not usually, reveals that the child's reaction to such events outside the home may still appear excessive, if not partially provoked by the child's own attitudes and personality which he brought to them.

I have been speaking still rather generally, perhaps, about the topic of etiology. Still, in a sense the general principles of etiology of persistent, and rather severe, emotional disorder in childhood of whatever form are no different from those of disorders and diseases which are the result of impersonal factors, that is, of infections, trauma and so forth. In other words, there is no single event or factor which *inevitably* determines the occurrence of a given disorder any more than a given bacterial organism, specific trauma or other non-personal factor always and by itself determines a given sequel in a recognizable organic disease syndrome. Just as a certain quantitative relation between some degree of susceptibility of the organism at a given period of its life and the virulence of the assault upon it of the specific external, environmental factor — bacterium, virus, trauma or whatever — is necessary to produce that reaction of the organism we know as organic disease; so it is with psychiatric emotional disorder. It is the *intensity* of the external interpersonal influences, and the *duration* of their operation as well as the *age* or *maturational phase* of the human organism during which it experiences them which in various combinations *together* produce what one writer has called the "*anthropological*" *variations*,[2] those personality organizations which the rest of us feel and consider as different from ourselves and then call them neurotic, psychotic, psychopathic or just "a bit queer" and write about as "problem children."

This general etiological principle of the period of life, the intensity and duration of the disturbing influences needs perhaps still another word of elaboration. The greatest susceptibility to emotional disturbance is clearly the period of greatest biological and social dependence or helplessness—namely, infancy and early childhood. That period of complete inability to survive and grow without the care and protection of adults is also—contrary to the opinion of many people—the period when conflict and anxiety, tension and uncertainty in the parental or mothering persons have the most disturbing effect. There is now fairly well validated evidence that uneasiness in the mother has a prompt and often severe effect upon the infant's well-being. Because it cannot yet speak and tell us in so many words, it is difficult sometimes to believe that the newborn, the infant or the very young child under one or two years of age can really sense and react to the hidden feelings of its parents who seem so very eager for its welfare. Nevertheless, the various disorders of its physiological functions, from gastrointestinal upsets, skin disorders to irritability and that frequently fatal apathy of marasmus are its way of telling the adult world how it feels it is being treated. I am sure that many, if not all, of you are familiar with these infantile disorders from such writers as Ribble,[4] Spock,[5] Aldrich,[1] and many others. Hence I shall not go into the details. How the tensions of the mothering person, whether in the nursery or the obstetrical ward, or later in the home or elsewhere, are communicated to what seems a still mindless creature, who tends towards sleepy withdrawal except when hungry or cold or on uncertain support is a mystery only to the unobservant. Those who see, sense and grasp how the mother, who struggles against her own more or less unknown but unpleasant and disagreeable impulses towards her child, handles it—either very gingerly, clutching it too tightly or too loosely, and reacts with even greater vacillation to its every whimper, and so on—are not at all mystified at this emotional empathic linkage, as Harry Stack Sullivan[6] calls it, between mother and child. You will notice that I said "those who see, sense and grasp" because if we listen to the mother's story of it we will hear often no word of her subjective state; at most we will hear only her emphatic insistence how careful she has been. She may be able to

speak of her worry, of her anxiety only if she becomes convinced we are sympathetic and not likely to blame or minimize, or deride her feelings about not being an adequate and a good mother. Often we are unable to hear from her any confirmation of our suspicions as to her subjective state in the first or even several interviews. Instead we may hear insistent demands to tell her what is wrong with the child, what should be done for it and so on. If we even gently ask for some details about what happens at times when she feeds it, changes diapers or on other similar occasions, we may evoke an indignantly angry reaction to the effect that *that* has nothing to do with it, that she knows nothing about it, that she follows every detail of the rules of care given her, and, besides, aren't we the doctors and cannot we tell what is wrong by examining the child?

Such reactions of defensive resentment often make the doctor uncertain, uneasy about his hypothesis and half angry at himself and at the mother. If, on the other hand, the mother is the sort who tells more freely what *she* feels, she may finally weep and otherwise be so upset *and ashamed of it* that the doctor may be again embarrassed and feel somewhat helpless at the emotional storm on his hands. In any case, even if the mother's emotional state *is* obvious and perhaps obviously related to the condition of the child, what can one do about it? Often some soothing words, a sedative for the mother or child, or some change in formula or in some other detail of regimen ends the particular episode for the particular doctor who may or may not hear that the child has been taken on subsequent occasions to other, perhaps many other, doctors.

Whatever the factors in her present and past life which contribute to the mother's anxiety in the first year or the first two years of the child's life, they may or may not be sufficiently ameliorated so that the child does or does not experience recurrently or persistently an extremely disagreeable tension within himself when in contact with the anxious mother. If the mother's anxiety is not relieved or ameliorated by what the doctor does or by some change in her life situation or both, it is easy then to see why the child at two or three years of age or later shows some disturbance in emotional and interpersonal development. In general, the more intense the anxiety of the mother—and usually also of the father—the *earlier* in his life and the *longer* the child experiences it, the more severe his personality disorder later and the more likely is he as an adolescent or adult to react with crippling emotional illness to even minor thwartings. The specific exaggerations of interpersonal behavior, the symptoms of the disorder, whether of the neurotically inhibited variety, or of some disturbance in acquiring self-control of egocentric impulses, or of both, depends on the particular rigidities or vacillations of the parental attitudes. The child usually, if not always, mirrors the personality problems of the parents; his symptoms and his behavior reflect how he has been treated, which generally also reflects how the parents treat themselves. This is a generalization which may be difficult to confirm in any given clinical instance only if we do not spend an equal amount of time, patience and skill in learning to know the parents as well as the problem child, or if we prefer some theory about obscure genetic, constitutional factors, and disease of the brain and glands as being the preeminently important determinants of deviations of personality development.

This very brief review of etiology brings us to the problem of therapy. Therapy by the specialists generally consists of talking, of interviews with one or both parents *and* with the child, unless he is between two and a half and seven or eight years of age, in which case the therapist and child spend their time together in a play room. Whether the frequency of the meetings between the child and his therapist and those between the parent or parents and their therapists are the same, or whether the child is himself the object of most or of all the therapeutic attention, varies. In private treatment (especially psychoanalytic treatment) the child may have roughly one-hour sessions several times a week for months with the child analyst while one or both parents are in psychoanalytic treatment with other analysts, or are seen in occasional conferences with the psychoanalyst of the child. In many, if not perhaps in most, psychiatric out-patient clinics for children, in which the therapeutic staff may not have been trained psychoanalytically, the traditional division of labor is that the psychiatrist sees the child in the playroom or office in which there are such toys as dolls, doll furniture, crayons and paper, plasticene, finger paints and so forth, while the clinic psychiatric social worker sees the parent, most often the mother, in interviews. The sessions in such clinics are usually less frequent than in psychoanalytical treatment, generally about once a week. There are, here and there, some differences of practice. In some clinics the clinical psychologist—the third member of the professional clinical team—may also engage in some therapeutic interviews in addition to his traditional, clinical job of psychometric and other diagnostic testing. In other clinics, if the staff has more than one psychiatrist and they are trained for psychotherapy, the child and parent may be both treated by psychiatrists. This is especially true if the problem is severe. There is still considerable debate in this field as to whether the interviews with the parent are an essential part of the therapy, especially when conducted by a social worker, or are especially then to be called "casework." In a few instances one hears of efforts by one and the same therapist — especially in private practice — to see therapeutically both the child and parents—at different times, of course.

I hardly know whether to include some institutional types of attention to problem children as therapeutic in the strict sense. Various homes and special schools, especially when small and operated privately, give some domiciliary care and training

to children with various emotional and/or intellectual handicaps. Hospital wards for children, residential treatment centers, must also be mentioned under children's psychiatric facilities, although they may vary in their theoretical orientation and hence in forms of therapy. Hospital wards for children are either parts of urban psychiatric hospitals, often teaching and research institutions, such as the ward at Bellevue Hospital in New York, at the Illinois Neuropsychiatric Institute in Chicago, or at the Langley Porter Clinic in San Francisco, or are special units on state hospital grounds such as at Camarillo and Napa State Hospitals in California. Whether the parents also receive therapeutic attention from the staff of such institutions depends upon many factors, such as the size and training of the staff, the number of children that must be cared for and the possibility of parents being able to come regularly enough and frequently enough to the hospital.

If we leave out of discussion the insulin, electroshock therapies with which I have no experience in the case of children's disorders—although I understand they are performed in various places—we may very briefly review the principles of psychotherapeutic work in child psychiatry. I say psychotherapeutic because the so-called "play therapy" is perhaps also more properly called psychotherapy. As one of my colleagues[2] once wrote, many people play with children, but they do not for this reason do any therapy. Play is for the child merely a partial substitute for speech in the child-psychotherapist emotional interaction and communication. A child, when sufficiently eased, in time, of his uncomfortable feelings in the presence of the trained adult therapist, may express some of his conflicting attitudes in play more spontaneously than in speech, just as the adult may be more able to do it in what is technically known as "free-association." In either case, whether with adult or child, with speech or with both speech and play as the mode of preferred communication between them, the patient and therapist begin what hopefully develops into an emotionally significant relationship. If this does develop—and whether it does or not depends upon many factors such as the frequency of the meetings, the duration of the therapy and, not least, the special training, skill and capacity of the therapist to understand the feelings and conflicts of children—if it does develop, there is then some chance that the child may begin to *feel* differently about himself, first in the presence of, and in relation to, his therapist, and later more generally with, and in relation to, most other persons in his life. This different feeling about himself in favorable or more successful instances is in the direction of sturdier self-respect, more realistic and more tolerant self-esteem for his actual assets and limitations, greater capacity to permit himself to *feel* whatever he feels in any situation but with a greater discrimination and greater fairness to himself and to others as to how he will express these feelings in action. In short, one hopes for at least some reduction—if not resolution—of his conflicts and self-destructive impulsiveness.

The details of the mutual work of both patient and therapist and of such phenomena as the "transference" which may eventuate in some such result cannot be dealt with cursorily. I wish, however, briefly to add a word about my own theoretical and practical inclinations with respect to the contribution of the therapy of parents to this possible therapeutic result in the child's feelings, attitudes and behavior. What seems to be clear to me both theoretically from what I have said previously and validated in a large measure in my own clinical experience is the following: As I have emphasized already, children, although individual human beings, are inevitably at the same time members of the family, their own biological family or another socially more or less their own. They are, in more impersonal terms, partially autonomous, component units of a larger, an organic system or unity. I think there is sufficient evidence also to say that the kind of persons or social entities they are or become results in a great measure from this fact. I find it convenient and useful, therefore, to consider their behavior, feelings and attitudes—their personality organization, in other words—as expressive of the kind of family social unit or system of which they are a part. To repeat what I said previously, the way they feel and act reflects how they have been treated by the adult persons who care for them. How these persons have treated them expresses or reflects how these adults basically feel towards themselves. Hence, an emotionally disturbed child to me indicates unhappy parents in the same way that a sick organ indicates or expresses a sickness of some sort or degree of the entire organism. In the case of the sick organism we know as physicians that it may not be enough — if it ever is — to treat only the sick organ. As a matter of fact, in more and more diseases we are learning that treating the entire organism is often more important than the sick organ, and now and again the most direct way towards restoration to health of this sick organ.

I am sure I need not labor the analogy further. If you review your own clinical experience from this point of view, I am rather confident you will find confirmation for the statement that helping a parent or *the family as a whole* to greater happiness, integration, mental health or however you wish to term it, is often an important and at times the most direct way to help an unhappy child. I must add immediately two things: First, we may at a certain juncture in the life of another person be unable either to do much or to do anything at all to help him feel and live more contentedly; and, second, to say that helping a parent is important does *not* mean that direct help to the child is unimportant or unnecessary. It is —as in the case of the organism with an obviously very sick organ—a matter of flexible, clinical judgment, of available therapeutic armamentarium, of time, of severity of disturbance in all parts of the

system, and of the easiest avenue of approach. In terms of the family with a problem child, it is his age, the severity and chronicity of his disorder, as well as the therapeutic availability of his mother, father or their substitutes, and the time, skill and personnel which together determine whether all three will receive therapeutic attention, or only two or one of them.

What constitutes "therapeutic availability" needs another bit of explanation. I mean by this term not merely whether the father as well as the mother, in addition to the child, have the time and there is some financial possibility of giving each of them some therapist's time, but even more important, whether any one, two or all three of them are basically more or less ready and more or less *willing* even to begin to work out their individual and therefore common problems and conflicts with a therapist.

In any case, it is certain that any change, whether towards integration or the obverse in any component part or member of the familial social system will affect other parts or members or the entire unity. And this is what we see clinically in child and father if mother only is helped to feel a more solid self-esteem or in any other combination. Clearly, if both the parent or parents as well as the child can be given assistance simultaneously, there is — other things, such as therapeutic skill and time, being equal—greater chance of quicker or more thorough therapeutic results. By the same token, the more severe the disorder, the more likely is some positive therapeutic result to follow the more total treatment of the entire family.

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